



HealthSmart (PEIA WEST VIRGINIA)
PROVIDER DEMOGRAPHIC DATA FORM

EFFECTIVE DATE: _____

PROVIDER LAST NAME AND SUFFIX: _____

PROVIDER FIRST NAME: _____

PROVIDER MIDDLE NAME: _____

DEGREE: _____

SPECIALITY & SUBSPECIALTY, IF APPL: _____

TAX ID. NO.: _____

PRACTICE NAME: _____

PRACTICE SITE ADDRESS: _____

MAILING ADDRESS (IF DIFFERENT): _____

COUNTY: _____

TELEPHONE NUMBER: _____

CLAIMS PAYMENT ADDRESS: _____

CONTACT PERSON NAME AND TITLE: _____

NAME OF PERSON COMPLETING
THIS FORM: _____

PHONE NUMBER: _____

PLEASE RETURN THIS COMPLETED FORM AND A COPY OF THE
PRACTITIONER'S LICENSE AND W-9 FORM.
HEALTHSMART (PEIA WEST VIRGINIA)
PO BOX 2451
CHARLESTON, WV 25329
1-888-440-7342 TOLL FREE 1-304-353-7629 PROVIDER RELATIONS –
1-855-405-0948 FAX NUMBER